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ABSTRACT

Two questions facing the therapeutic community right now are: Can machines replace therapists? and Can therapy occur without a therapist? This paper attempts to respond to these questions through an examination of some major Western and Eastern theories in the field of psychological therapy. It reviews existing writings in the field to emphasize that, whatever improvement may occur through the use of technology, psychotherapy builds a personal relationship between two or more individuals, and that it is through this personal relationship that therapeutic change occurs. To eliminate or limit this personal relationship in any way will inevitably destroy the essence of therapy. The brief overview of some of the writings of theorists concurs that therapy is an effective way of changing the thoughts, feelings, and behaviors of human beings, and the relationship between the client and the therapist lies at the very heart of therapy. A brief examination of the benefits of technology concludes that the amount of data available through a computer dramatically increases the resources and knowledge of the therapist and client. (Contains 42 references.) (JDM)

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Theoretical Perspectives on the Importance of the Therapeutic Alliance and Their Implications for the Use of Technology

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The Western process of providing therapy to individuals, couples, families, and groups has depended primarily upon the presence of a trained therapist since Freud developed his "talking cure" in the late 19th Century. Even before that, any historical perspective makes note of the fact that individuals in a society or culture, although variously seen as participants in magic, religion, philosophy, or medicine, were designated to fulfill the role of "helper/healer." (Wachtel, 1977, p.3; Orlinsky & Howard, 1995, p. 4.) Eastern traditions of healing relied similarly upon the mentor, guru, or priest to guide the seeker toward increased mental, physical, and emotional health.

However, much has been made in recent years of the advances of technology and their implications for the spread of knowledge. Not only has the World Wide Web opened up undreamed of access to job listings, psychological tests, published works, and reference materials, but advance in multi-media material are making it easier to use and bring audio and visual materials into the counseling session. Advances in phone technology have allowed communication between individuals to occur anywhere at any time. The advantages of technology have been targeted in the United States, in the provision of mental health services, by managed health care organizations and by agencies and businesses, all eager to cut down the costs incurred through standard delivery of psychotherapy. If video tapes, or computer programs, can replace an actual person and, once developed, can be reused innumerable times for a minimal cost, then to what extent is the person necessary in the delivery of mental health care? The basic questions in the therapeutic community might be stated at these: Can machines replace therapists? Can therapy occur without a therapist?

This paper attempts to respond to these questions through an examination of some major Western and Eastern theories in the field of psychological therapy. It is the purpose of this paper to review existing writings in the field of psychotherapy to emphasize that, whatever helping may occur through the use of technology, it is the very essence of psychotherapy that a personal relationship occurs between two or more individuals and that it is through this personal relationship that therapeutic change occurs. Therefore, to limit or eliminate this personal relationship in any way through the use of technology will inevitable destroy the essence of therapy.

Most Western theories may be divided into three major "schools" or "Forces": Psychodynamic, as elaborated upon by Object Relations theorists, Margaret Mahler, John Bowlby, and the advocates of Self Psychology; Behavior Modification and Cognitive/Behavior Modification, as defined by B. F. Skinner, Albert Bandura, Michael Mahoney, David Meichenbaum, Aaron Beck, Salvador Minuchin, Jay Haley, and others; and the Humanistic/Phenomenological/Existential Theorists, represented by Carl Rogers, Frederick "Fritz" Perls, Irving Yalom, Rollo May, Abraham Maslow, and Virginia Satir, for example.

Each of these Forces has distinctive views of human nature, the nature and mechanisms of change, the role of the therapist, the goal of therapy, the course of therapy, success in therapy, and each contains different sets of techniques, strategies and interventions based on these concepts. Regardless of the differences in views, values, and opinions expressed by these different Forces and the specific theories in each Force, the most common element amongst the theories is the central importance of the therapist. (Fiedler 1949; Fiedler 1950)

Indeed, as Orlinsky and Howard (1995) state:

"Thus, the modern psychotherapies may be described generically as involving a *professional service* that provides *personal help* in the sphere of *private life* under the symbolic authority and guidance of *scientific knowledge*...This combination of professional service with personal attachment as contrasting and even contrary social structural elements into a single relationship is a distinctive feature of the modern forms of psychotherapy...(p. 9) Another aspect of the process that follows directly from the therapeutic contract is the start of a person-to-person relationship between the patient and therapist. This *therapeutic bond* may be kept in the background and given only limited recognition or it may become an important focus of treatment, depending mainly on the therapist's treatment model and the patient's personal input. However, whether the bond is overtly emphasized or not, research has show that it is centrally related to the therapeutic outcome." (p.17)

First Force theories have emphasized the necessity of the objective nature of the therapist. The therapist should not interject him/herself into the therapeutic process in a personal way. This would seem to advance the idea that a machine, which in theory could be programmed to do analysis and interpretation, would be the ideal partner for the client from the psychodynamic perspective. But wait! The briefest perusal of the literature from this Force quickly puts this idea to rest.

Sigmund Freud (1964), the "father" of psychoanalysis, said it this way:

"The labour of overcoming the resistances is the essential achievement of the analytic treatment; the patient has to accomplish it and the physician makes it possible for him to do this by suggestions which are in the nature of an *education*. It has been truly said therefore, that

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psychoanalytic treatment is a kind of *re-education*. (p. 459) The decisive part of the work is carried through by creating - in the relationship to the physician, in "the transference" - new editions of those early conflicts, in which the patient strives to behave as he originally behaved, while one calls upon all the available forces in his soul to bring him to another decision. The transference is thus the battlefield where all the contending forces must meet." (p. 462)

Freud's one time disciple and another of the "Big Three" of First Force theory, Alfred Adler (1979), wrote:

"Part of the technique of treatment is in any case information on these aspects, and extension of the ability to cooperate. This is the core of Individual Psychology treatment. In the cooperation between physician and patient I have greatly stressed how the patient must be brought closer to the problem, so that he is slowly brought into this path of cooperation until it appears to him as a matter of course. The result is the extended ability to cooperate. This puts him in a better position." (p. 200)

And the last of the original "Big Three", Carl Jung (1933), states:

"It is only with the help of confession that I am able to throw myself into the arms of humanity freed as last from the burden of moral exile. The goal of treatment by catharsis is full confession...(pp. 35-36) For twist and turn the matter as we may, the relation between physician and patient remains personal within the frame of the impersonal, professional treatment. We cannot by any device bring it about that the treatment is not the outcome of a mutual influence in which the whole being of the patient as well as that of the doctor plays its part. Two primary factors come together in the treatment – that is, two persona, neither of whom is a fixed and determinable magnitude. Their fields of consciousness may be quite clearly defined, but they bring with them beside an indefinitaly extended sphere of unconsciousness. The this reason the personalities of the doctor and patient have often more to do with the outcome of the treatment than what the doctor says or thinks...The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed. We should expect the doctor to have an influence on the patient in every effective psychic treatment: but this influence can only take place when he too is affected by the patient. You can exert no influence if you are not susceptible to influence." (p. 49)

Sullivan (1954), one of the group of theorists called Neo-Freudian, explains his view of the role of the therapist thus:

"Since the field of psychiatry has been defined as the study of interpersonal relations, and since it has been alleged that this is a perfectly valid area for the application of scientific method, we have come to the conclusion that the data of psychiatry arise only in participant observation. In other words, the psychiatrist cannot stand off to one side and apply his sense organs, however they may be refined by the use of apparatus, to noticing what someone else does, without becoming personally implicated in the operation. His principal instrument of observation is his self - his personality, *him* as a person. The processes and the changes in processes that make up the data which can be subjected to scientific study occur, not in the subject person nor in the observer, but in the situation which is created between the observer and his subject. We say that the data of psychiatry arise in participant observation of social interaction, if we are inclined toward the social-psychological approach, or of interpersonal relations, if we are inclined toward the psychiatric approach, the two terms meaning, so far as I know, precisely the same thing. There are no purely objective data in psychiatry, and there are no valid subjective data, because the material becomes scientifically usable only in the shape of a complex resultant - *inference*. (p. 3) As I said at the beginning, psychiatry is peculiarly the field of participant observation...Therefore, the psychiatrist has an inescapable, inextricable involvement in all that goes on in the interview; and to the extent that he is unconscious or unwitting of his participation in the interview, to that extent he does not know what is happening." (p. 18)

Murray Bowen, founder of Family Systems therapy, is Neo-Freudian in his perspective. Even within the context of treating a family, he emphasizes the importance of the relationship with the therapist. He states: "The major characteristic to be examined here is that *the successful introduction of a significant other person into an anxious or disturbed relationship system has the capacity to modify relationships within the system.*" (Bowen, 1985, p. 342)

Ah, but what of the cognitive/behavioral theories? This Second Force relies much on the strength of its techniques and has been criticized for not valuing the therapeutic relationship. Once again, although touting the efficacy of strong techniques, writers in this domain recognize the centrality of the counseling relationship.

Joseph Wolpe is considered one of the founders of Behavior Therapy. He, however, supports the notion of the importance in therapy of the client-counselor relationship by writing:

"The most enviable feature of behavior therapy is in the command it gives to the therapist, both in general planning of his therapeutic campaign and in modifying its details as he goes along...The power to intervene rationally and predictably makes a striking contrast to the uncertainty of the conventional therapist's position...This being the case, it is not surprising that the literature on conventional psychotherapy gives so much weight to the patient-therapist relationship...As Frank has shown, a relationship is which the therapist is able to mobilize the patient's expectation of help and hope of relief is in and of itself a powerful therapeutic instrument...The procedures of behavior therapy have effects additional to these relational effects that are common to all forms of psychotherapy. The practice of behavior therapy may thus be viewed as a 'double-barrelled' means of alleviating neurotic distress." (Wolpe, 1973, p. 9)

Aaron Beck (1979), one of the leading proponents of cognitive therapy, further supports this view by stating:

"The general characteristics of the therapist which facilitate the application of cognitive therapy (as well as other kinds of psychotherapies) include warmth, accurate empathy, and genuineness...We believe that these characteristics in themselves are necessary but not sufficient to produce an optimum therapeutic effect. (p. 45) Having considered the therapeutically valuable attributes of the therapist, let us focus on the development and maintenance of a therapeutic relationship. The relationship involves both the patient and the therapist and is based on trust, rapport, and collaboration. Cognitive and behavior therapies probably require the same subtle therapeutic atmosphere that has been described explicitly in the context of psychodynamic therapy." (p. 50)

Constructivism is one of the cognitive theories, which emphasizes the subjective nature of experience. One theorist writes:

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"In keeping with their conceptualization of human beings as incipient theorists or narrators of their experience, constructivists envision the basic goal of therapy as the promotion of this meaning-making activity rather than the 'correction' of presumed dysfunctions or deficits in the client's thinking, feeling or behaving. Therefore, in assessment, constructivists concentrate on identifying and eventually reformulating the central metaphors that inform the client's self-narrative as well as personal and shared systems of meaning that prove impermeable in the face of novel experience. This typically carries the constructivist therapist to relatively deep levels of intervention, or second-order change, with a focus on the basic selfhood process...As a process-oriented approach to therapy, constructivism encourages a delicate attunement of the often-inarticulate questions implicit in the client's behavior and attempts to help the client weave through his or her experience threads of significance that lead either to provisional answers or toward better, more incisive questions. Ultimately, the aim of therapy is to create a personal and interpersonal atmosphere in which presenting problems can be reformulated and resolved in language and in which clients can recruit social validation for new, less 'problem-saturated' identities." (Neimeyer, 1995, pp. 17-18)

Narrative therapy is considered a form of constructivist therapy. White and Epston (1990) are among the leading proponents of this form of work. They have stated:

"Insofar as the desirable outcome of therapy is the generation of alternative stories that incorporate vital and previously neglected aspects of lived experience, and insofar as these stories incorporate alternative knowledges, it can be argued that the identification of and provision of the space for the performance of these knowledges is a central focus of the therapeutic endeavor." (p. 31)

The Mental Research Institute in California developed a form of behaviorally oriented Brief Therapy considered especially useful for families. In a book considered a classic exposition of this form of therapy, Fisch, Weakland and Segal (1982) write:

"Given this conception of problems and their resolution, the therapist must be an active agent of change. Not only must he get a clear view of the problem behavior and of the behaviors that function to maintain it; he must also consider what the most strategic change in the 'solutions' might be and take steps to instigate these changes - in the face of the clients' considerable commitments to continuing them. This is the job of the therapist as we see it... (p. 19) It may seem cold and calculating to talk about ways of controlling the process of treatment, but we believe it is evident, on little reflection, that the client is not in a position to know how his problem should best be approached - if he did, why would he be seeking professional help? Accordingly, almost all therapies involve tactics for providing the therapist control of the course of treatment...This is not for the arbitrary purpose of controlling, per se. Rather, it is ethically consistent with our view that the guidance of treatment is an inherent responsibility of the therapist and that it is to the patient's detriment if the therapist abdicates this responsibility." (p. 22)

William Glasser developed Reality Therapy, which is considered rather "hard nosed" and is especially effective with dysfunctional adolescents. Glasser (1965) has a clear view of the importance of the therapeutic alliance, as he states:

"Unless the requisite involvement exists between the necessarily responsible therapist and the irresponsible patient, there can be no therapy. The guiding principles of Reality Therapy are directed toward achieving the proper involvement, a completely honest, human relationship in which the patient, for perhaps the first time in his life, realizes that someone cares enough about him not only to accept him but to help him fulfill his needs in the real world." (p. 21)

Albert Ellis, developer of Rational Emotive Behavior Therapy, is also viewed as a pragmatist, and although he has advocated the possibility of self-analysis, he admits to the central role of the therapist:

"As we often explain to our psychotherapy patients and marriage counseling clients...it is not what the therapist tell the individual that helps this individual overcome his emotional disturbances, but what the patient or client *does* with what the therapist tells him. More concretely: although the effective therapist must somehow teach his patients to think straight, he cannot at any time really think *for* them...This means that therapy, in essence, largely consists of teaching the patient effective self analysis..." (Ellis & Harper, 1961, p. 6)

Richard Stuart has applied behavioral principles to work with couples. He has also indicated the central role the relationship with the therapist plays in therapeutic change:

"In this active approach to treatment, as in the interpersonal approach, the therapist has the responsibility of controlling the therapeutic interaction. It is the job of the therapist to create a therapeutic environment that facilitates the clients' acceptance of change-inducing instigations as much as it is the job of the therapist to render instigations wisely, to evaluate the effects of the intervention, and to use this evaluation-produced feedback to redesign the methods that are used. The power that the therapist must use to do these jobs well must be developed through interaction with the clients..." (Stuart, 1980, p. 149)

Salvador Minuchin (1981), developer of the behavioral family therapy known as Structural Therapy, states:

"Family therapy requires the use of self. A family therapist cannot observe and prove from without. He must be a part of a system of interdependent people. In order to be effective as a member of this system, he must respond to circumstances according to the system's rules, while maintaining the widest possible use of self." (p. 2)

It is undisputed that Third Force has emphasized the importance of the relationship between the therapist and the client. Indeed, this is sometimes seen as the distinctive feature of Third Force theories. A sample of writing confirms this view.

Carl Rogers, founder of Person Centered Therapy (previously called "client centered therapy") has explained the importance of the therapist-client relationship thus:

"In client-centered therapy the client finds in the counselor a genuine alter ego in an operational and technical sense...In the therapeutic experience, to see one's own attitudes, confusions, ambivalences, feelings, and perceptions accurately expressed by another, but stripped of their complications of emotion, is to see oneself objectively, and paves the way for acceptance into the self...In the emotional warmth of the relationship with the therapist, the client begins to experience a feeling of safety as he find that whatever attitude he expresses is understood in almost the same way that he perceive it, and is accepted....In this safe relationship he can perceive for the first time the hostile meaning

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and purpose of certain aspects of his behavior, and can understand why he has felt guilty about it, and why it has been necessary to deny to awareness the meaning of this behavior... The therapist perceives the client's self as the client has known it, and accepts it; he perceives the contradictory aspects which have been denied to awareness and accepts those too as being a part of the client; and both of these acceptances have in them the same warmth and respect. Thus it is that the client, experiencing in another an acceptance of both these aspects of himself, can take toward himself the same attitude. He has been enable to do this because another person has been able to adopt his frame of reference, to perceive with him, yet to perceive with acceptance and respect." (Rogers, 1965, pp. 40-41)

Gestalt therapy was developed by "Fritz" Perls, who writes:

"Our view of the therapist is that he is similar to what the chemist calls a catalyst, an ingredient which precipitates a reaction which might not otherwise occur. It does not prescribe the form of the reaction, which depends upon the intrinsic reactive properties of the materials present, nor does it enter as a part into whatever compound it helps to form. What it does is to start a process, and there are some processes which, when once started, are self-maintaining or autocatalytic. This we hold to be the case in therapy. What the doctor sets in motion the patient continues on his own." (Perls, *et al.*, 1951, p. 15)

Rollo May (1957), writing about Existential Therapy, states:

"Another thing to be noticed about this patient who has come to my office is that immediately there is a relationship... The patient, like all beings, has the need and possibility of going out from his centeredness to participate in other beings. He is now struggling with the possibility of participating with the therapist... (pp. 94-95) To be able to sit in a real relationship with another human being who is going through profound anxiety or guilt or the experience of imminent tragedy taxes the best of the humanity in all of us. This is why I emphasize the importance of the 'encounter' and use that word rather than 'relationship'... Encounter is what really happens; it is something much more than a relationship. In this encounter I have to be able, to some extent, to experience what the patient is experiencing. My job as a therapist is to be open to his world. (p. 108) ...As I sit now in relationship with my patient, the principle I continue to assume is: this being, like all existing beings, has the need and possibility of going out from his centeredness to participate in other beings. (p. 119) I would put it...that the task of the therapist is to help the patient transmute awareness into conesciousness." (p. 126)

Virginia Satir, a humanist who first wrote of Conjoint Family Therapy, and later called her work the Human Validation Process Model, was particularly succinct about the centrality of the therapist: "If one uses the growth model, one must be willing to be more experimental and spontaneous than many therapists are. The necessity of flexibility in technique and approach, including particularly direct, intimate contact between patient and therapist, is thought to be basic." (Satir, 1983, p. 234)

Prochaska and Norcross (1994), looking at the entire broad range of therapies in all three Forces, explain:

"Psychotherapy is at root an interpersonal relationship. The single greatest area of convergence among psychotherapists in their nominations of common factors and in their treatment recommendations is the development of a strong therapeutic alliance. Furthermore, as predicted earlier, this most robust of common strategies has generally emerged as one of the major determinants of psychotherapy success. Still, the desirable type and relative importance of the therapeutic relationship are areas of theoretical controversy...In light of these various emphases on the role of the therapeutic relationship in the conduct of psychotherapy, it will be necessary to determine for each therapeutic system whether the relationship is conceived as (1) a precondition for change, (2) a process of change, and/or (3) a content to be changed." (pp. 8-9)

This very brief and necessarily limited overview of some of the writing of theorists in all three Forces of the field of therapy has, hopefully, reminded the reader that the theorists in this field were aware of what innumerable research studies have indicated: That therapy is an effective way of changing the thoughts, feelings, and behaviors of human beings (Lambert, 1992), and the relationship between the client and the therapist lies at the very heart of therapy. As one textbook compares and contrasts different theoretical perspectives by stating:

"First, if it is assumed that the source of many, if not most, of the problems of clients involve disturbed interpersonal relationships, then a therapeutic relationship that includes the characteristics of a good human relationship is a relevant, and specific, method of treatment...Indeed, therapy would be limited if it attempted to help the client develop better interpersonal relationship in the context of a different kind of relationship...The second argument against the view that the relationship is nonspecific is the research on relationship (nonspecific) variables. There is evident that the providing of the relationship as defined here, without any additional techniques, is effective with many clients who have many kinds of social-psychological or interpersonal problems." (Patterson & Watkins., 1996, p. 500)

Or, as another theorist puts it:

"The therapeutic relationship may very well be the major variable in certain forms of psychotherapy, such as those associated with the psychodynamic and existential-humanistic models and with the newer feminist therapy model. Certainly we learn more about the nature and importance of this relationship from these models than we do from others. Perhaps for those clients who want or need brief problem-solving approaches, technique or medication is more important than relationship, even though relationship is always important as the context for technique. As sociocultural pressures continue to have an eroding impact on family and interpersonal relationships, a qualitative relational therapy often becomes the experiential springboard from which clients can learn to refocus their priorities and to find their self-in-relation. We all have our biases and preferences. While I have enormous respect for each of the major models and utilize them all in some ways at different times, for me the therapeutic relationship provides a critical context for what strategies are utilized to effect intellectual and emotional awareness and to develop competency skills. The connection between therapist and client allow for effective connections between approaches and problems, between theory and practice." (Okun, 1990, p. 410)

This is also pointed out by Kottler (1991):

"Of all the elements we might name, none receives more attention - both in theory and in practice - than the alliance between client and therapist. It is the glue that binds everything we and the context for every intervention. A productive, open, and trusting relationship is, quite simply, the single most necessary prerequisite for effective psychotherapy (as we currently know and understand it) to take place....The existential or humanistic therapist places primary emphasis on a relationship...All other types of clinicians - regardless of their espoused

allegiances or belief systems - also spend some time developing a relationship that they consider to be necessary for anything else they might do. Most contemporary psychoanalysts, for example, no longer maintain the strict neutrality that was originally advocated by Freud, but rather seek to establish a more authentic encounter. And even those orthodox practitioners who do believe in maintaining a degree of distance so that transference feelings are not compromised still believe that *their* relationship with a client is central to the analytic work that follows. Behavior and cognitive therapists will also now readily acknowledge that their interventions are likely to be more effective if implemented within the context of a relationship that is trusting and open." (pp. 48-49)

Indeed, effective therapy depends upon the efficacy of the therapeutic alliance. As Fancher (1995) succinctly states: "It would seem reasonable to expect psychotherapists to know true things about the human psyche and its problems, and to expect that this knowledge is essential to effective therapy. Recent research has complicated this issue even further. The therapist, perhaps more than the technique, seems to be what counts...Somehow it seems the person, more than what she knows, determines success... Such data are quite consistent with the possibility that personal characteristics or intrinsic healing powers, not professional expertise, account for results." (P. 21.)

To supplement a deeper understanding of the complexities of the therapist-client relationship, the reader is directed to several wonderful books that elaborate extensively on the power of the therapeutic relationship in therapy: Auld & Wyman (1991), Guggenbuhl-Craig (1971), Kahn (1991), Kell & Mueller (1966), and Teyber (1992).

In summary, as one writer states, "There is nothing wrong with influencing the patient; indeed, without the therapist's influence on the patient, there is no therapy worthy of the name. Like it or not, the therapist is influential, he cannot escape that responsibility; the art of psychotherapy lies in promoting and then using one's influence skillfully." (Basch, 1980, p. 6)

Although Asian therapies differ substantially from common Western practice, the element of the importance of a helper is still central. In a discussion of Eastern therapeutic regimes, including yoga and meditation, Morita and Naikan therapies, one commonly used textbook states, "The spectrum of relationships is almost as broad for Asian therapies. Some foster transference, other minimize it; in some the relationship is primary, in others definitely secondary. However, instruction and assistance from a skilled helper is regarded as essential in all Asian practices, which are never entirely solitary." (Walsh, 1995, p. 388) Even when describing meditation, Walsh (1981) says: "In fact, there is *relatively little need* for professional time and energy *once the basic practice has been established*." (p. 487, emphasis added.).

In discussing Shadan, a Zen rest cure, Bankart (1997) states: "Shadan therapy begins with complete rest and more or less total social isolation for up to 30 days. During this period, the patient often may be permitted to communicate directly with only one person, the therapist..." (p. 471) The same author, in discussing Shiatsu massage, says: "This relaxation should be understood as involving the entire aspect of their two persons, including not only touch but also bodily motions and breathing. Through this interaction, the two people develop a deep awareness of each other and of their relationship. Indeed, in Shiatsu the effects of the massage are at least as transpersonal and emotional as they are physical." (p. 482)

In a discussion of Morita Therapy, Reynolds (1981) mentions: "Morita therapists are explicitly directive. They are teachers, experienced guides who, for the most part, have surmounted their own self-imposed limitations through this method. Although the therapist offers authoritative advice, he does express genuine interest in the patient. Avoiding a cold, authoritarian approach, he seeks to establish rapport knowing that a positive relationship will facilitate the therapy process." (p. 493)

Another author reminds the reader that, in particular, Naikan therapy uses the *sensei* as an integral part of the therapy. (Sharf, 1996, p. 567) As Reynolds (1981) formulates the relationship in Naikan therapy: "During each interview the therapist simply listens humbly and gratefully to the outpouring from the client. The therapist then assigns the next topic, answers questions, and perhaps offers a word of encouragement, such as 'Reflect deeply, please.'" (p. 548) For a more extensive look at Morita therapy, including how the Morita therapist acts as surrogate parent for the client, and Naikan therapy, the reader is directed to Reynolds (1976).

Now, for a *very brief* examination of the possible benefits of technology. There is no doubt that increasing experience increases knowledge and increased knowledge does lead to change. Thus, access to the a variety of assessment instruments, psychological and interest tests, such as the Myers-Briggs Type Indicator and the Strong Interest Inventory, easier and more comprehensive access to job listings, the availability of information about disorders and accompanying support groups for them, and the almost unbelievable amount of data to be reached through a computer - what books have been written, what articles have been published - increases dramatically the resources of both the therapist and the client. Cellular telephones have made the therapist more present to the client than could have been thought possible. Using videotape and audiotape for the client to receive instant feedback on his/her performance is so wonderfully cogent and non-judgmental that any therapist might seriously consider the use of these aids.

But if there is, as research indicates, an agreement that therapy is one of the effective means of changing human behavior and enhancing well being, the pull to replace the therapist with any of the technological mechanisms making their way into the marketplace today must be resisted. It is useless to discuss whether or not the therapist needs to exist in order for therapy to exist. "The helping personal attachment makes psychotherapy an engagement between human beings and emphasizes the nature of the bond that forms between them." (Orlinsky and Howard, 1995, p. 9) Or, as stated by Kottler (1986): "It is not what the therapist does that is important - whether she interprets, reflects, confronts, or role plays - but rather who she is...The first and foremost element of change, then is the therapist's presence..." (pp. 2-3)

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Unless we are willing to move to a completely new paradigm for the helping of people, one that has not existed in the previous history of human beings, the relationship between helper and helpee is central to the process and cannot ever be replaced by machines.

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